

COVID-19 Free-of-Charge Testing Encounter & Consent Form



Last Nai	me:		First Name:	Middle	Name:	Birth	n Date:
Address	:	Street:		I			
(Not a PO Box)		City:State:				Zip:	
Home P	hone:		Cell Phone:			Gender: [\Box M \Box F
Race:		can Indian/Alaskan Natiian Native or Other Pac		□Black or Africa □White □Not St		Hispani □ Yes	c/Latino: □No
epartment cords will ght years o H is require	of Health (be retained ufter birth.	-45.1 of the Code of Virginia	O-19 test on me an te of the last visit, oyed in a manner t ED CONSENT FO (1950), as amended	d/or my dependent, a and in the case of a nata assures confiden R HIV, HEPATITIS Is to give you the follow	s named above ninor, the recor- tiality througho B OR C TESTIN ing notice:	. I understand the did will be retaine ut the process and G	at medical d for twenty- nd in its result
smit diseas ther health est results 2. If you sase, that pe	se, your blood care provide to the persot should be di erson's bloo	rectly exposed to blood or bood will be tested for infection v	with human immuno e test. Under Va. Co dy fluids of a VDH h vith human immuno	deficiency virus (HIV) de § 32.1-45.1(A), you health care professional	as well as for He are deemed to have worker or employed	epatitis B and C. A ave consented to the oyee in a way that	A physician ne release of may transmit
		will tell you and that person the RECEIPT received the Notice of Privacy	OF THE NOTICE	OF PRIVACY PRACE Virginia Department of			i physician of
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 \square Positive Result – Follow-up needed (see exception notes)